

Contra Costa Health Plan

Utilization Management

Title: Standard Reconsideration Process for Medicare Enrollees

Policy #: UM15.026

Origin Date: 10/7/97,12/22/97, 1/18/98
Revised: 6/99, 12/99, 6/00, 4/03, 11/03,
12/04, 10/05, 3/06, 10/06, 11/06, 2/09
Revised: 10/2016, 01/2019
Reviewed 5/2015, 3/2016, 10/2016, 04/2017,
01/2018, 01/2019
Reviewed: 03/2021, 6/2021

Author: Dee Patrick, QM Director
Author: Florence Chan, Auth/UM Director
Reviewer: Lynn Soloway RN, Auth & UM Director

Reviewer: Dennis Hsieh, MD, JD, CMO

Approved by Quality Council: 6/9/16, 4/27/17,
12/14/17, 2/28/19, 6/2021, 7/2023
Presented in UM Committee: 6/2023

Applies to:

- Medi-Cal
- Commercial

- Medicare
- BHC

- Social HMO
- State Sponsored

Regulatory/Accreditation:

- DMHC
- Other Related Policies:

- DHCS
- NCQA

- CMS
42CFR Part 422 Sec 422.578

Units:

- Administration
- Business Services
- Marketing

- Advice Nurses
- Case Management
- Member Services

- All Staff
- Health Ed/Cultural Ling.
- Planning, Survey, Reg Affairs

This Policy is Not Applicable to Pharmacy Determinations

POLICY

Contra Costa Health Plan (CCHP) ensures a timely reconsideration process is available to Medicare enrollees or their authorized representative for requesting a reconsideration of a denied or modified service or a denied claims payment. The reconsideration process is available to Medicare enrollees, who have been issued a CCHP denial, in whole or part, for a requested service that the member believes should be furnished or arranged for by CCHP, or for the termination or reduction of a service that the member believes is still needed.

PURPOSE

To document the reconsideration process for Medicare enrollees and their representative, and to apprise delegated and non-delegated Health Plan providers of CCHP's reconsideration process.

PROCEDURE

I. WHO MAY FILE A REQUEST

An enrollee, their authorized representative, an assignee of the enrollee (a physician or other provider who has furnished a service to the enrollee), or a legal representative of a deceased enrollee's estate may request a reconsideration. If a representative request the appeal, the representative must be a court appointed guardian or an agent under an appointment of representation statement to the extent provided under state law. **Please note, the enrollee's treating physician may request a standard plan reconsideration on behalf the enrollee**

without having been appointed as his or her representative. In lieu of evidence of legal guardian/agent, a signed Appointment of Representation Statement will need to be sent to and signed by both the enrollee and the assignee of the enrollee to process an appeal designating an assignee. A copy of the guardianship or the signed Appointment of Representative Statement is kept in the appeal file.

II. METHODS OF FILING A REQUEST

The request for standard reconsideration must be submitted in writing to the Member Services (MS) Department. The MS Department will monitor and track the reconsideration process and will act as the “contact point” for the enrollee. The MS Department will also generate any written communications to the member. **The request for reconsideration must be received by CCHP no later than 60 days after notification of a denial or modification for requested services but may be extended for good cause.** Written requests for reconsideration may be submitted to the Social Security or with the Railroad Retirement Board if the member is a railroad annuitant.

III. ASSIGNMENT OF CASE FILE

Upon receipt of a request for an appeal of a denied or modified service in the Utilization Management (UM) Department from MS Department, a designated Appeals Liaison is assigned to the case. The case file from MS is reviewed and determined if additional information is needed and/or required to make an appropriate determination. As necessary, the Appeal Liaison contacts the requesting provider to request reasonably necessary information to make a determination.

The Appeals Liaison will be responsible for documenting all communication pertinent to the appeal request in the MS Appeal File and keeping accurate timeline records. Upon receipt of the requested information for providers or the member, the case file is forwarded to a UM nurse, not involved in the original determination, and the case is reviewed for medical necessity. A brief summary of findings is documented by the UM nurse in the case file. A UM Case Review is prepared by the UM nurse and submitted to the Appeals Committee for review determination.

IV. TIMEFRAME FOR THE RECONSIDERATION PROCESS

The timeframe for a standard reconsideration process is as follows:

1. Standard Service Reconsideration

A 30-day* timeframe is allowed for prospective or concurrent service requests, which were denied or modified by the Health Plan and do not meet the criteria for an expedited reconsideration. An extension of up to 14 business days is possible if requested by the enrollee or if the Plan finds that additional information is necessary, and the delay is in the interest of the enrollee. If the 14-day extension is needed, the enrollee will be notified and updated periodically on the status of the reconsideration during the 14-day period. The written notification will include the necessary tasks during the extension period and the time estimated for completion.

Please note: The extension period increased from 10 to 14 days on January 1, 2006.

2. Urgent Service Reconsideration

In general, expedited reconsiderations must be completed as soon as it is medically indicated, but no longer than 72 hours, with a possible extension of up to 14 calendar days if the delay is in the enrollee’s interest. Examples of cases that should be expedited include pre-service skilled nursing facility cases, pre-service acute

inpatient care cases and cases in which a physician indicates that applying the standard timeframe for making a determination could seriously affect the life or health of the enrollee or the enrollee's ability to regain maximum function.

Please note: The extension period increased from 10 to 14 days on January 1, 2006.

If the requested additional information is not received by the end of the 14-day extension period:

The enrollee will be notified in writing that requested information was not received and the Health Plan will make a determination based on the information available for review. A case file will be prepared and sent to Maximus/Center for Health Dispute Resolution (CHDR) within 24 hours of the final determination. The UM staff member will prepare and forward the case to Maximus/CHDR and request a "dismissal" since requested information was not received for review.

3. Standard Claims Reconsideration

A 60-day timeframe is allowed for all reconsiderations related solely to a denial of claim payment or reimbursement. Claims reconsiderations may not be expedited. Claims reconsiderations do not have a possibility of an extension period.

V. APPEAL COMMITTEE DETERMINATION

Once all reasonably necessary information is received from the provider and a UM Case Review is prepared by the UM staff member, the case will be presented in the Appeal Committee. After a determination has been made, the enrollee and provider will be notified as follows:

If the original determination is overturned:

Written notification to the enrollee and provider of the determination is issued by Member Services within the 30-day* service or 60-day claim timeframe for a standard reconsideration. If necessary, the designated UM staff member will assist the enrollee in facilitating the services to be rendered.

If the original determination is upheld:

The enrollee and the provider will be issued a written notification of the determination by Member Services and will be informed that a copy of the case file is forwarded to the Maximus/CHDR for a final determination. The designated UM staff member will prepare and forward the case file to Maximus/CHDR within the 30-day* or 60-day timeframe. Upon notification of final determination from Maximus/CHDR, final action will be taken, and case will be closed.

PLEASE NOTE: If a service is not covered by traditional Medicare but is covered by CCHP as an additional benefit; the reconsideration process under DMHC guidelines applies to the denied or modified service(s).

TOTAL DELEGATION:

If the Health Plan provider is totally delegated for Utilization Management activities, their internal denial and appeal process is used. On no less than a biannual basis, the representative or designee from the delegated provider presents a report of appealed services and its outcomes to Quality Council for review. CCHP maintains ultimate responsibility for the reconsideration process for the member. The delegated entity's case files are reviewed onsite during the annual delegation audit.

PARTIAL DELEGATION:

Partial delegation occurs when the delegated entity conducts only some of the utilization management activities. If the Health Plan provider is not delegated to conduct the appeal process for CCHP members, they must be aware of and be able to explain the reconsideration process available through CCHP and Maximus/CHDR as well as the Department of Managed Health Care (DMHC) complaint process to the member. The delegated entity may assist the member by preparing a written appeal to CCHP, Maximus/CHDR or DMHC.

The written request and a copy of the denial notification are forwarded to CCHP Member Services for the initiation of the above reconsideration process. Once the request is received in the CCHP UM Department, the case is logged into a UM tracking database. Even though the case is entered into a UM database, the MS Department is responsible for overseeing member appeals.

**Per Center for Medicare and Medicaid Services (CMS) guidelines the 30-day service reconsideration timeframe can extend an additional 14 days for a total turnaround time of up to 44 days.*